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Testimony to the Michigan House Committee on Health
TOPIC: Maternal Mortality in Michigan
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Honorable members of the Committee on Health of the Michigan House of Representatives: It is my privilege today to speak with you regarding the challenges – and also the opportunities for improvement – regarding maternal mortality in our state.

I applaud this committee for devoting the time in today's meeting to maternal mortality, which is a topic of emerging concern for our state. While this legislature, the Department of Community Health, and many communities and stakeholders around the state have devoted considerable effort and appropriate attention to the problem of infant mortality over the last several years – and we are starting to see some signs of improvement in this key measure of our state's overall health – the companion challenge of maternal mortality has received far less attention.

I say "companion challenge" because when we describe maternal mortality in medical or public health terms, we are talking about women who die within 12 months of the end of a pregnancy. Sometimes these deaths are directly associated with situations that occur related to pregnancy, such as bleeding, infections, or problems such as strokes and heart attacks that are related to high blood pressure. In other situations, maternal deaths occur that are not directly related to pregnancy; for example, a mother with an infant may die in a motor vehicle accident.

As you can imagine, these deaths are a tragedy – each one of them. There are 5 to 6 dozen pregnancy-associated deaths in Michigan each year – on average, one to two women every week. We are here today because we believe that a large number of pregnancy-associated deaths in Michigan are preventable. We know this because we have a very thorough system in Michigan for analyzing the reasons for women's deaths within one year of pregnancy, called maternal death review and the Maternal Mortality Surveillance System.

It is my pleasure this morning to appear with two talented and accomplished physicians, whom I am privileged to call my colleagues in health care here in Michigan. Dr. Cheryl Gibson-Fountain will speak about the most recent guidance from the American College of Obstetrics and Gynecology regarding the challenge of maternal mortality, and what women's health providers are doing across the state. Dr. Sonia Hassan will speak to the particular challenges of maternal mortality in Detroit, and what she and her colleagues are doing to address those challenges.

As an introduction to my colleagues' presentations, I will now provide some brief, key observations regarding maternal mortality and the perspectives of the Department of Community Health regarding the opportunities to address this problem in the very short term here in our state.

1 – Maternal mortality is increasing across the United States, and in Michigan as well.
-- After decades of steady decreases following World War II, maternal mortality reached its lowest level in the United States by about 1990. Subsequently, from 1995 through 2011 (the most recent year of data), maternal mortality in the US increased more than three-fold (from 7.1 per 100,000 live births to 23.6 per 100,000 live births).

-- From 1995-2011 in Michigan, maternal mortality increased more than four-fold, from 6.7 per 100,000 to 29.0 per 100,000. In addition, there is a more than three-fold higher rate of maternal mortality for African American women in Michigan than for non-Hispanic white women.
-- The United States is the only Western industrialized country to have an increase in maternal mortality from 1995-2011. Nearly all states have contributed to the national increase during this period. While improvements in measuring maternal deaths have led to some of this trend, a major concern is that women are entering and completing pregnancy in worse health than in prior generations.

2 - The causes of maternal mortality are strongly connected to women's overall health – not only during pregnancy, but before conception and after delivery.
-- During the most recent years of maternal mortality data for which causes of death have been identified (2005-2010), 46% were due to obstetric or medical causes. Obstetric problems are related to the pregnancy and delivery itself, such as bleeding and infection. Medical causes of maternal mortality include health problems such as high blood pressure, diabetes, and obesity which are tied to life-threatening problems such as heart disease, stroke, and blood clots. To address these causes of death, it is essential to identify women's health problems *prior to conception,* so that women can receive appropriate medical care and public health outreach.
-- 54% of maternal mortality in Michigan was due to causes *other* than obstetric and medical. This category includes motor vehicle accidents, violence/assaults, suicide, and substance abuse. To address these causes of death, it is essential to continue to engage women in health care and public programs after their pregnancies end.
-- The central message here is that we can be successful in reducing maternal mortality if we are successful in addressing the health needs of women of reproductive age, whether they are pregnant or not. Today, a major way that the State of Michigan supports the health needs of women is by providing coverage in the Medicaid program during pregnancy for poor and low-income women. However, this coverage ends for 1 out of 5 women on Medicaid at the conclusion of their pregnancy and does not begin again unless and until they become pregnant and seek coverage again the future. In other words, the traditional approach to Medicaid coverage in Michigan is missing 2 periods of need that we know are contributing to maternal mortality: pre-conception health and post-partum health.
-- In contrast, the Healthy Michigan Plan that this legislature passed in 2013 and that MDCH has implemented since April 2014 has a more comprehensive approach to women's health. Of the more than 385,000 people who have enrolled in the Healthy Michigan Plan so far, more than 127,000 (about one-third) are women of child-bearing age (19-44 years old). These Healthy Michigan enrollees have access to health care before, during, and after pregnancy. To address maternal mortality, Michigan can follow its own lead and modify the parameters of traditional Medicaid to incorporate a more comprehensive approach to women's health before, during, and after pregnancy.

3 - Maternal mortality varies according to geographic regions in Michigan.
-- We know from our Maternal Mortality Surveillance System that the pattern of maternal mortality varies across our state. For the counties where the population is large enough to have reliable measures of the maternal mortality rate, we see the following pattern for the years 2008-2011: Detroit (131 deaths per 100,000 live births), Genesee (127), Macomb (94), Wayne (90), and Oakland (60).
-- High rates of maternal mortality in the counties of our state with the largest population and largest numbers of birth highlight the importance of (a) coordinated efforts across the health care and public health communities in each of these high-population-density areas to address maternal mortality, and (b) intensified efforts in locations with the highest mortality burden.

I will now ask my colleagues to provide their comments regarding these challenges and opportunities.